

Welcome!



John J. Metz, DMD, MS

Kids & Teens Medical & Dental Health History Form

Child's Name _____ SSN _____ Date of Birth _____

Parent 1: Name _____ Cell# _____ Relationship _____

Occupation _____ Employer _____ Work phone _____

Parent2: Name _____ Cell# _____ Relationship _____

Occupation _____ Employer _____ Work phone _____

Guardian: Name _____ Cell# _____ Relationship _____

Occupation _____ Employer _____ Work phone _____

Phone at Child's Primary Address _____

Child's Primary Address _____

City _____ State _____ Zip _____

Email _____ Check box above for person responsible for account ----- 

Health History: Does your child have, or has your child ever had, any of the following conditions:

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Hyperactive
<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Infectious Diseases: (Circle)
<input type="checkbox"/>	<input type="checkbox"/>	Asthma			Herpes HIV Tuberculosis Hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease
<input type="checkbox"/>	<input type="checkbox"/>	Cleft Lip & Palate	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease
<input type="checkbox"/>	<input type="checkbox"/>	Delayed Speech Development	<input type="checkbox"/>	<input type="checkbox"/>	Pregnant
<input type="checkbox"/>	<input type="checkbox"/>	Developmentally Delayed	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Problems
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever
<input type="checkbox"/>	<input type="checkbox"/>	Emotional Disturbances	<input type="checkbox"/>	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	<input type="checkbox"/>	Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Anemia
<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss/Impairment	<input type="checkbox"/>	<input type="checkbox"/>	Other _____
<input type="checkbox"/>	<input type="checkbox"/>	Heart Condition			_____

CONTINUED ON BACK

Is your child currently seeing a physician? _____ Why? _____

Physician's Name: _____

Is your child taking any medications? Yes No If yes, please list:

1. _____ 3. _____
2. _____ 4. _____

Has your child ever been hospitalized? Yes No If yes, please explain:

Dental Health:

Yes No

- Has your child ever had a toothache?
 Has your child ever received a blow or injury to his/her teeth?
 Does brushing cause his/her gums to bleed?

Why is your child here today? (Main orthodontic concern)

When was your child's last dental appointment?

Does your child think there is anything wrong with his/her teeth? Yes No

Maturation:

Yes No

- Has he/she begun puberty?
 If patient is a girl, has menstruation begun?
 If patient is a boy, has his voice changed or does he have facial hair?
 Has the patient grown in the last year, or shoe size changed?
 Has either biological parent had orthodontic treatment?
 Is the child interested in orthodontic treatment?

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform any necessary dental services that my child may need during diagnosis and treatment with my informed consent.

Signature of Parent/Guardian _____ Date _____